State Politics and the Creation of Health Insurance Exchanges

Health insurance exchanges are a key component of the Affordable Care Act. Each exchange faces the challenge of minimizing friction with existing policies, coordinating churn between programs, and maximizing take-up. State-run exchanges would likely be better positioned to address these issues than a federally run exchange, yet only one third of states chose this path. Policymakers must ensure that their exchange—whether state or federally run—succeeds. Whether this happens will greatly depend on the political dynamics in each state. (*Am J Public Health.* 2013;103: e8–e10. doi:10.2105/AJPH.2013.301429)

David K. Jones, MSPH, MA, and Scott L. Greer, PhD

ONE OF THE MOST IMPORTANT components of the Patient Protection and Affordable Care Act of 2010 (ACA)[1] is the creation of health insurance exchanges. Exchanges will be online marketplaces through which individuals and small businesses will shop for health insurance. The goal of an exchange is to expand coverage for previously uninsured populations while increasing transparency in the health insurance marketplace by enabling consumers to compare plans in a standardized way. The exchange will also be the mechanism through which qualifying individuals receive subsidies from the federal government to purchase private insurance coverage. It is estimated that 24 million people will receive insurance through an exchange by 2016.[2]

Every state will have an exchange, although states have had to decide whether to create the exchange themselves or cede control to the federal government. Public opinion is divided over the ACA as a whole, yet exchanges were not expected to be controversial in their own right. Republicans endorsed organized marketplaces for insurance in the past and even supported state insurance exchanges during the legislative battles over the ACA.[3] A November 2012 Associated Press poll found that 63% of Americans preferred a state-run exchange; 32% favored federal control. Among Republican respondents, 81% preferred state control.[4] However, after 3 years of contentious debates, only 17 states and the District of Columbia chose to create an exchange themselves. Six chose to partner with the federal government, and the remaining 27 states chose to allow the federal government to develop and run their exchange.[5] States can take control of their exchanges at any point in the future. However, a state that inherits a federal structure will have lost the opportunity to make decisions that will dramatically affect both what the exchange strives to accomplish and whether it succeeds. This includes shaping whether the exchange is run inside government or as a nonprofit organization, the role of the exchange in determining what plans can be sold, how the exchange is financed, the role of insurance agents and brokers, and whether interest group representatives sit on the board of directors.

The ACA was written with the assumption that states would take the initiative to create their own exchange. The law gives the Department of Health and Human Services authority to fund the creation of state-run exchanges and provide subsidies through state-based exchanges but includes no specific authorization to provide subsidies through a federally run exchange.[1] Neither did the department receive resources to create federally run exchanges. It has had to divert this money from other parts of its budget.

Opponents offer several reasons for being cautious about creating a state exchange. For example, state policymakers have complained that federal guidelines have taken too long to develop and that creating an exchange commits them to restrictions of which they are not yet aware.[6] Second, frustration over lack of federal guidance is compounded by a fear of hidden costs. Opponents worry that exchanges will be more expensive than expected and that states will ultimately be burdened by these additional costs.[7] Finally, some argue that states would not have much control anyway and would function as a vendor for the federal government.[8]

Although we believe that the benefits of state-run exchanges outweigh these concerns, it may be that there is no single answer to the question of whether a state should have created its own exchange. A state exchange would stand no chance of success if run by leaders who were uncommitted or even belligerent toward the idea. That only 17 states chose to create an exchange should not necessarily be viewed as a failure for the administration of President Barack Obama. This may be the ideal outcome. Every state will have an exchange, and early adopter states will benefit from flexibility and grant money when they design their own exchange. These states will serve as a natural experiment through which the rest of the country can observe the advantages and disadvantages of each model.

THREE CHALLENGES

Implementing this component of the reform will present policymakers with 3 linked challenges.

The first is friction. Each state has unique market characteristics and legacies of state policy and regulation. Some states are dominated by a single insurer; others have more competition. In some states, community rating or bans on preexisting condition exclusions will be new with the ACA, whereas others made these changes years ago. State-run exchanges can be designed with these, and other, variations in mind. Federal exchanges might not fit well with existing state legacies and markets.

The second challenge will be churn. State-level control of an exchange facilitates better coordination with Medicaid and the Children's Health Insurance Program (CHIP). This is particularly important in light of the concern that people with incomes fluctuating near eligibility thresholds will move between programs, leading to disruptions in coverage and care. It will be difficult for federal regulators to tailor policies to local conditions in many states at the same time, thereby exacerbating the incongruities in states that chose not to run their exchange or did not expand their Medicaid program.

Third, the success of the exchanges will depend on whether individuals and small businesses participate—the challenge of take-up. Experience with the early phase of Medicare Part D and CHIP suggests that take-up may be slow initially but can improve as policymakers focus on increasing enrollment.[9] States are likely better positioned than the federal government to succeed at consumer outreach and education. In addition to understanding their own markets, they can partner with local stakeholders who bring credibility and visibility. For example, the Boston Red Sox played a prominent role in publicizing Massachusetts' exchange.[10] The Obama administration is providing grants to community organizations engaged in enrollment in the states that opted not to do an exchange. However, the $54 million currently allocated to be spread over 33 states will likely not be enough, and it will be difficult for the Obama administration to secure more funds from Congress.

The most important issue for policymakers and stakeholders is no longer whether their state should have created an exchange. Regardless of which path a state chose, policymakers should now focus on overcoming these challenges and ensuring that their exchange succeeds. The extent to which this happens will depend greatly on the political dynamics in each state.

POLITICS OF IMPLEMENTATION

Republicans across the country are divided over the exchanges.[3] They are reluctant to be seen as implementing part of a law they campaigned against but do not want to give control to the federal government. Many Republican governors and legislative leaders delayed making decisions until after the Supreme Court upheld the constitutionality of the ACA and President Obama won reelection. Even then, very few decided to move forward with their own exchange. Of the 30 Republican governors in office in 2013, only 4 are presiding over the creation of an exchange. One Republican-led state chose the partnership model, and the remaining 25 defaulted to a federal exchange.

Leaders in states with a federally run exchange now face a choice. They can work behind the scenes with the Obama administration to ensure that their state's exchange succeeds, they can do nothing and simply stay out of the way, or they can actively work to undermine the exchange's success. The optimistic view of their political incentives is that now that the decision is mostly out of the legislatures and public attention to the exchanges is diminishing, Republican governors will allow their bureaucracies to work with the Obama administration in a de facto partnership. A pessimistic, and perhaps more realistic, view is that Republicans will continue attempts to undo the law by remaining uncooperative. Because the ACA is so closely associated with President Obama and Democrats, many Republicans see little to gain politically by supporting their state's exchange, but much to be gained by helping it fail. In many cases, the best that can be hoped for is that they stay out of the way.

Republican leaders in "blue" states have the strongest incentive to either support implementation or stand aside. In 2013 and 2014, Republicans will be defending governors' seats in 23 states, including 9 that voted for Obama in both 2008 and 2012. Regardless of whether the state chose to create a state-run exchange (Nevada) or to default to a federal exchange (Florida, Maine, Michigan, New Jersey, Ohio, Pennsylvania, Virginia, and Wisconsin), Republican leaders in these states may need to focus more on appealing to moderates in both parties than on pleasing the most conservative wing of their party. Making sure their state's insurance exchange succeeds is an opportunity for such bipartisan cooperation. However, even if these governors are willing to support implementing components of the ACA, they could be blocked by coalitions of legislators whose incentive is to appeal to the preferences in their districts rather than in the entire state. For example, the Republican-controlled Michigan Senate was able to prevent the creation of a partnership exchange despite support from Governor Rick Snyder (a Republican) and approval from the Department of Health and Human Services, by not allowing state agencies to spend federal grants they had received.

The solidly blue states with Democratic leadership will demonstrate what the ACA is like when implemented by governments that want to reap its advantages and that are comparatively undisturbed by the contentious politics of the law. This includes large states such as California, medium-sized states such as Oregon, and small states such as Rhode Island, along with Vermont, which is attempting to establish a statewide single-payer system. The framers of the ACA might have wanted more such examples, but the successes and failures of these states will determine perceptions of the law, its long-term sustainability, and whether other states eventually seek control over their exchange.

CONCLUSIONS

Although the Affordable Care Act drew on Republican policy ideas of the 1980s and 1990s, its passage was polarizing and hotly contested. As ever, the politics of a bill do not stop with passage, and state and federal implementation processes become political arenas. Policymakers and practitioners implementing the exchanges face 3 challenges: friction, churn, and take-up. Their responses will vary with the partisan politics of their

state as politicians balance enthusiasm for or against the law, public opinion, and their interest in solving concrete implementation problems. Practitioners and policy analysts in the different states and the federal government should focus on building constructive partnerships and policies that manage these issues and exploit state action when it is forthcoming. ■

About the Authors

The authors are with the Department of Health Management and Policy, School of Public Health, University of Michigan, Ann Arbor.

Correspondence should be sent to David K. Jones, 1415 Washington Heights, Ann Arbor, MI, 48109 (e-mail: davidkj@umich.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted April 28, 2013.

Contributors

Both authors conceptualized and wrote the article.

Acknowledgments

We thank Helen Levy for her valuable comments.

Human Participant Protection

No protocol approval was required because no human participants were involved.

References

1. Patient Protection and Affordable Care Act of 2010, Pub L No 111-148, § 1311 (2010).

2. Congressional Budget Office. Health insurance exchanges: CBO's March 2012 baseline. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43057_HealthInsuranceExchanges.pdf. Accessed April 13, 2013.

3. Jones DK, Bradley KWV, Oberlander JO. Pascal's wager: health insurance exchanges and the Republican dilemma. *J Health Polit Policy Law.* In press.

4. Alonso-Zaldivar R. States reveal their choices on Obama's health law. Yahoo! News. 2012. Available at: http://news.yahoo.com/states-reveal-choices-obamas-health-law-091517091-politics.html. Accessed April 18, 2013.

5. State decisions for creating health insurance exchanges, as of May 28, 2013. Kaiser Family Foundation. Available at: http://www.kff.org/health-reform/state-indicator/health-insurance-exchanges/#map. Accessed June 6, 2013.

6. Walker S. Choice is clear: let feds create exchange. *Milwaukee Wisconsin Sentinel Journal.* November 17, 2012. Available at: http://www.jsonline.com/news/opinion/choice-is-clear-let-feds-create-exchange-to7ld9p-179748071.html. Accessed April 18, 2013.

7. Republican governors decide against setting up Obamacare insurance markets. Fox News. 2012. Available at: http://www.foxnews.com/politics/2012/11/16/republican-governors-decide-against-setting-up-obamacare-insurance-markets. Accessed April 18, 2013.

8. Haislmaier EF. Even rebranded, Obamacare exchanges are still unworkable. Heritage Foundation. March 4, 2013. Available at: http://www.heritage.org/research/commentary/2013/3/even-rebranded-obamacare-exchanges-are-still-unworkable. Accessed April 18, 2013.

9. Cunningham PJ. SCHIP making progress: increased take-up contributes to coverage gains. *Health Aff (Millwood).* 2003;22(4):163–172.

10. Connector teams up with Red Sox to build enrollment in new health insurance plans. Boston Red Sox. 2007. Available at: http://boston.redsox.mlb.com/news/press_releases/press_release.jsp?ymd=20070522&content_id=1979252&vkey=pr_bos&fext=.jsp&c_id=bos. Accessed April 18, 2013.